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ABSTRACT

Two programs on drug, alcohol, and sex education in two Glasgow (Scotland) high schools were evaluated to assess their effectiveness. One was a drugs and alcohol education program at City High School and the other a sexual health program at Clydeside High School. Both schools drew from a local population that included a significant number of poorer, less educated families. The drug and alcohol program included two formats, a standard 10-week course delivered by a Personal and Science Development teacher and an alternative program designed and delivered by project workers from the local Health Board and addiction project. Both were designed to help young people make informed decisions about any potential use of drugs. The evaluation compared participants' views on the two different courses. The sexual health program had a particular focus on pregnancies among local young women who were thought to be leaving school and becoming pregnant soon after. The evaluation compared the views of pupils, researchers, and health workers before and after the program. Among the many findings were the following: students found the alternative drug program very relevant; those in the sexual health program felt the course had provided information they needed and enhanced their ability to make decisions. Three appendixes contain information on research methodology, program content, and research team members. (JB)

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A Report on Two Innovative School-based Programmes

Kevin Lowden
Janet Powney

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Drugs, Alcohol and Sex Education

A Report on Two Innovative School-based Programmes

Kevin Lowden
Janet Powney

SCRE
The Scottish Council for Research in Education

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Contents

Page

Acknowledgements

1 Context and Aims **1**

Context 1
Aims of the evaluation 3
The schools 3
The health education programmes 5
Research methods 6

2 Issues and Implications **7**

The relevance of the programmes 7
Communication between the health board and schools 8
Assessing the needs of pupils 9
Staffing 9
Programme content, teaching and length 11
Improving pupils' decision making 13

3 Evaluation Findings **15**

Drugs and alcohol: the findings 15
Issues for consideration 17
Sexual health: the findings 18
Conclusion and emerging issues 22

References **23**

Appendix 1: Research Methodology **24**
Appendix 2: Content of Programmes **28**
Appendix 3: The Evalution Team **30**

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Our advisory committee gave very constructive support throughout the project.

1 CONTEXT AND AIMS

Context

In recent years the profile of health education in Scotland has increased. In particular sexual health and substance misuse have received much attention. The media, has tended to highlight, and some would argue distort, health education in schools. The apparent rise in drug experimentation among school pupils across the UK, the way sexual health courses are taught and who receives them and the opinions of interested parties appear regularly across the media. To some extent the interest in these topics reflects the 'selling power' of controversial issues for newspapers but it is also a reflection of a real concern across the community about sexual health and particularly substance misuse especially where children are concerned. For example, the National Association of Headteachers at their 1994 conference demonstrated headteachers' concerns about the impact of pupils' drug use. Allegations were made of children turning to prostitution and crime to finance addiction or pay for experimentation. From this concern emerged a plea for a co-ordinated campaign of education about drugs and measures to prevent the selling of drugs within schools. Headteachers also demonstrated their anxiety about how effectively drugs education can be taught in schools, who should be doing it and in what form.

Research has shown that teachers are anxious about teaching sexual health and drug education and that they require guidance and support concerning the implementation of programmes. For example, Thomson and Scott (1992) in a survey of all local education authorities in England and Wales found:

> inconsistency in terms of the numbers of school sex education policies, LEA monitoring of sex education, levels of school governor training in sex education and in ...the leadership given to schools by local education authorities...widespread confusion concerning the place of sexual education in the National Curriculum, the nature and implementation of a cross curricular approach to the teaching of sex education...widespread anxiety at all levels (LEA and school) concerning the teaching of sex education. This anxiety was particularly acute in relation to the fears of parental, governor and 'community' disapproval as well as in relation to legislation.

Despite the debate about the ways in which sexual health and drugs education should be implemented it is clear that schools have an important role in encouraging healthy living. The salience of health education programmes which focus on drugs and substance misuse or sexual health would seem evident given the reports of increases in drug use among young people and the dangers posed by HIV infection. Research on young peoples' awareness of health compromising behaviour reveals that while many young people have a good grasp of, say HIV/AIDS, they still have quite serious gaps in their understanding of the facts and issues (MacKintosh and Eadie 1993, Currie, Todd and Wijckmans 1993b).

In Scotland, the educational sector appears to have responded to the challenge of implementing health education with local authorities developing policies on such education within their schools. Of the 12 local authorities 10 had formal health education policies when this project started in 1993. Research has shown the importance of the local authority taking the lead in developing such policy; secondary schools were far more likely to have a health education policy if one existed at regional level (Devine et al 1993).

In each school there is a designated teacher with responsibility for health education. In most schools this is usually a person at middle management level or above with regional guidance advising that co-ordinators should be appointed from the senior management team. Apart from work-load implications there are issues of how to liaise with departments within the school as well as parents and health agencies.

Changes in recent years to the school curriculum have had implications for school health programmes, as Devine (1993) observed:

> *The introduction of the 5-14 programme for Environmental Studies should ensure a core of health education for all primary and lower secondary pupils. For the first time there will be a nationally agreed curriculum which gives clear guidance on what should be included in a [school] health education programme and indicates a progression across the stages.*

Contacts between schools and specialist agencies and services, including local area health boards is widespread but varied in nature. Certain agencies, for example drug support services will tend to be reactive and provide resources and visits when asked. However, local health boards are usually more proactive with clear ideas on how their services can be applied. This does not mean they impose programmes rather, they negotiate with schools to design a suitable programme.

Other national initiatives have occurred which have provided resources for school health education. For example, two educational packages - Drugwise 10-14 and Drugwise 14-18, have been distributed to all educational authorities and the independent sector to be given be given to all primary, secondary and special schools. The Scottish Consultative Council on the Curriculum and HEBS have produced a reports to heighten awareness of health education issues.

In Scotland it appears then that there are grounds for cautious optimism in terms of the institutional structures and organisation which can support health education programmes. However, as our evaluation revealed there may be some way to go before the teachers involved with programmes feel comfortable with their participation in sexual health and drugs education.

As we have seen there have been moves towards greater collaboration between the health and educational services. In the case of Greater Glasgow Health Board's *Inequalities in Health Project*, the health board is providing services and innovative programmes which schools can draw on. The implementation of any new health education programme which is based on a collaboration between a school and a health board can exploit the strengths of both parties but also requires adjustment for all involved, including the pupils. The main question is whether or not the extra effort and resources put into these kinds of programmes benefits pupils. It is against this context that the Greater Glasgow Health Board

commissioned the Scottish Council for Research in Education (SCRE) to undertake an external evaluation of two school health programmes delivered jointly by teachers and project workers. The SCRE evaluation was intended to complement the Health Board's internal evaluations of the two programmes.

The two programmes, part of Greater Glasgow Health Board's wider *Inequalities in Health* Project, were :

- A Drugs (including smoking) and Alcohol Education Programme at 'City High School';
- A Sexual Health Programme at 'Clydeside High School'.

Aims of the evaluation

The main aims of our evaluation were to provide insights into the effectiveness of each programme in achieving its objectives. In particular the evaluation would:

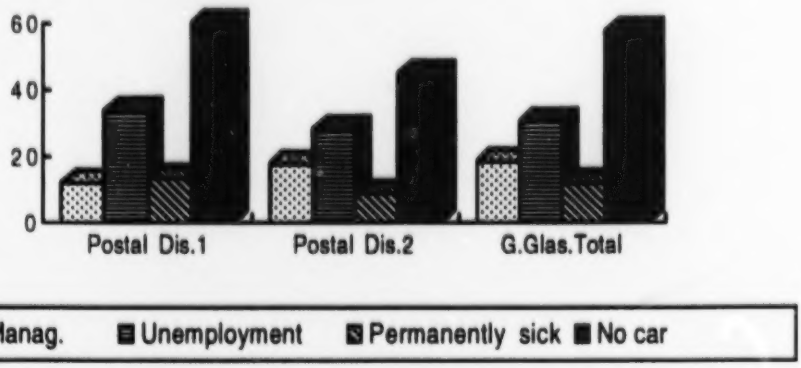
- examine the acceptability and suitability of the two programmes for both teaching staff and pupils;
- assess the success of the programmes in improving both pupil and teacher awareness and understanding of the subject matter;
- assess the ability of both programmes to develop relevant skills in pupils. For example decision-making skills;
- examine the extent to which the methods being used might have more widespread applicability in terms of use in other schools and in other health related programmes.

The schools

City High School

The school has approximately 1260 pupils and 90 staff. The 1991 population census statistics show the two postal districts comprising the catchment area for the school are quite different in terms of socio-economic class and also in their health characteristics with a correlation between lower socio-economic class and poorer health. The following figure provides some indicators of socio-economic class and health for the school's postal areas and the whole Greater Glasgow Area.

Figure 1: Comparisons between indicators of socio-economic class and health for City High School two postal districts

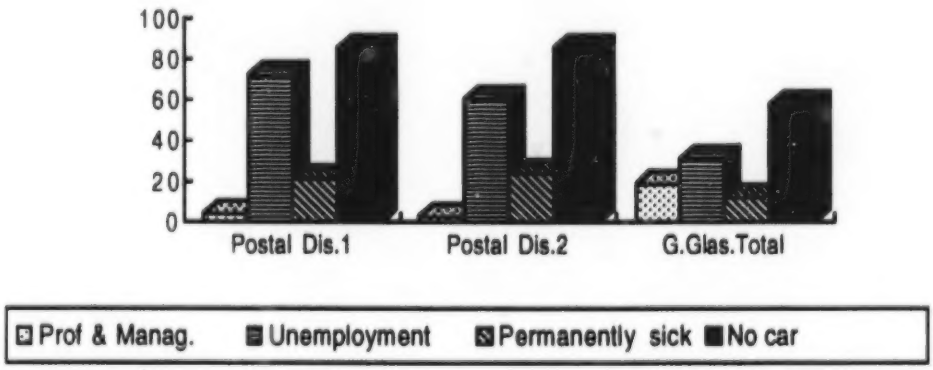


Any health education programme implemented in this area will have to take into account these differing populations. The Health Board's own statistics also reveal that slightly more (4%) parents in the lower socio-economic group in this area are likely to smoke compared with parents of the same socio-economic status in Greater Glasgow. Given the high probability of parents being smokers, it was an important aim of the health education programme to educate pupils about the dangers of smoking and reduce the likelihood of children imitating their parents' smoking behaviour.

Clydeside High School

The school has approximately 660 pupils and 60 staff. The 1991 population census statistics show the two postal districts comprising the catchment area for the school are generally similar in terms of socio-economic class and that the districts' health characteristics show a correlation between lower socio-economic class and poorer health. The following figure provides some indicators of socio-economic class and health for the postal areas and the Greater Glasgow Area. It is notable that the percentage of the area's population who are designated permanently sick (16 years - pensionable age) is almost double that for the overall Greater Glasgow area.

Figure 2: Comparisons between indicators of socio-economic class and health for Clydeside High School two postal districts



Overall pregnancy rates for women under 20 in the school's catchment area is higher than the average for Greater Glasgow. However Greater Glasgow Health Board's own statistics reveal an important difference between the two districts' health demographics. In one of the postal districts which makes up half of the school's catchment area in 1993, the percentage of women under the age of 20 who were having children was 17.4% compared to the average for the whole Greater Glasgow area of 8.3%. This rate had remained around this level for the past ten years. However, in the other half of the school's catchment area in 1993, the percentage of women under the age of 20 who were having children was 10.3%. This rate had decreased steadily from around 22% in 1983. It is not clear why one postal district has such different maternity rates among young women. There is no great social class difference across the community and it would be necessary to look at other social, cultural (eg, sub-cultures, religious values) which do not show in the statistical evidence for explanations for the differences between the

two postal districts. Nevertheless, the fact that one half of the area has far higher rates of women under the age of 20 who were having children than the overall average for the Greater Glasgow area, substantiates the need for a programme to address issues concerned with teenage and single parent pregnancies. Indeed, one of the reasons teachers at the school wanted the programme was to address the high rate of pregnancies in the community among young women who had recently left school.

The statistics in the two figures tell us that there is a correlation between poor health and low socio-economic class. Both schools include pupils who can be classified as socially disadvantaged and who are likely to have a particular need for health education programmes. Although long term improvement in these peoples' health requires the wider social causes of deprivation to be addressed, nevertheless health education can be seen as having a crucial role to play in ameliorating health inequalities. However, these contextual statistics do tell us that pupils in disadvantaged areas are not necessarily homogeneous groups and course designers and teachers have to take this into account.

■ The health education programmes

The drug and alcohol programme at 'City High'

In City High, pupils followed either the schools 'standard' ten weeks drug and alcohol programme or the alternative programme designed and delivered with the help of project workers from Greater Glasgow Health Board and the local addiction project. Both approaches were intended to increase pupils' knowledge and awareness of drugs, smoking and alcohol with a view to enabling young people to make informed decisions about any potential use of these substances. While the content of the two courses was broadly the same, the methods of delivery were different and would result in some detailed differences in emphasis in the emerging content. In summary:

- The 'standard' course –

  delivered by a Personal and Science Development (PSD) teacher using the *Drugwise* modules and based upon numerous worksheets many of which required self-completion. Teachers also deployed group discussion techniques as well as some videos;

- The 'modified' course –

  delivered mainly by a health project worker or local addiction project worker who had experience of drug and alcohol education with young people under the auspices of the Greater Glasgow Health Board. The PSD teacher worked in collaboration with a health project worker. The teaching methods were more varied than in the standard classes and included discussion groups, videos (the same as used on the standard course), role-play and the use of various texts including thematic information sheets which formed a poster when put together, and some aspects of the *Drugwise* module.

The SCRE evaluation compared participants' reactions to, and perceptions of the effectiveness of, the different approaches used in the modified and standard courses.

The sexual health programme at 'Clydeside High School'
The programme was designed on the basis of negotiation between the school and health workers from Greater Glasgow Health Board with the aim of gearing the content to the needs of the school. One of the school's concerns was the need to address the relatively high levels of pregnancies among young women in the local community. It was felt that many young women were leaving school and becoming pregnant soon after.

The duration of the programme was 10 weeks and was delivered to S1, S2 and S3 pupils in single sex groups by the health workers who had experience of sexual health education with young people under the auspices of the Greater Glasgow Health Board. The teaching methods were varied and included discussion groups, self-completion and reading material, some role-play and quizzes.
The actual content or syllabus varied slightly depending on the age group receiving it and was modular based on the 'Skills for Adolescence' teaching package (see Appendix 2).

The evaluation compared the views of pupils, researchers and health workers before and after the programme.

■ Research methods

In evaluating the two programmes we gathered information from pupils, project workers and teaching staff in the two schools using similar research methods, refined in discussion with the Health Board and the project workers. Their advice was particularly useful in adapting our research instruments to suit pupils' differing levels of knowledge, experience and literacy. Details of the research methods are included in Appendix 1. All the staff (teachers and health workers) working on both programmes were interviewed in groups at appropriate times and were extremely helpful in illuminating the issues relevant to the programme evaluation.

Pupils' views were gained through discussion groups and from self completion sheets designed by the researchers. The pupils were very interested in the subject area and their enthusiasm helped the researchers to obtain substantial evidence of their views.

2 ISSUES AND IMPLICATIONS

In this section we draw on the findings of the two evaluations to highlight issues related, more widely to the implementation of health education programmes in schools. These points are intended to inform practitioners who design and implement such programmes, those who draw-up guidelines for health education as well as policy makers who can affect the extent and nature of these programmes. The issues focus on:

- relevance of the programmes
- communication between the health board and schools
- assessing the needs of pupils
- staffing
- programme content, teaching and length
- improving pupils' decision-making

The detailed findings specific to the two programmes we evaluated are given in Chapter 3.

The relevance of the programmes

Our evaluation showed that the content of both the sexual health and drug and alcohol programmes was perceived as very relevant by most teachers and all pupils. Upon completion of both programmes, the pupils were extremely satisfied with the relevance of the content and were anxious that there would be subsequent programmes to reinforce what they had learned but also to update their knowledge about the subjects so as to reflect their needs as they grew older.

If other schools have similar needs to the two we evaluated, then there must be a strong demand for sexual health and drug and alcohol programmes from schools and in particular from their pupils. Overall, the programmes were seen by almost everyone involved as relevant to aspects of modern life which require information and personal strategies to aid young people in making informed decisions to help avoid potentially health threatening situations.

Issues concerning content

At both the schools the pupils who received the programmes were unanimous in their praise for the suitability of the programme content (details in Appendix 2). However, there was some concern among the teachers involved with the two programmes about aspects of the content, and this was particularly the case at the start of the programmes. For example, on the modified drug and alcohol programme there was concern from one teacher that the content might be inappropriate for those pupils unlikely to find themselves in drug-related scenarios. However, the pupils did not appear to share this concern, rather, they felt that the programme content was not just appropriate but essential. Also, we could question the validity of the viewpoint that some pupils will never find themselves in drug-related scenarios.

On the sexual health programme, the teachers felt that the content was extremely relevant to pupils needs but were concerned about the style of language used in discussions. Most of these worries appeared to be based on teachers' fears that parents might complain about what their children were learning on the programme if pupils used some of the slang terms they had heard from peers in the classes. However, by the end of the programme teachers' concerns diminished as more information filtered back to them about the courses, especially from pupil feedback.

It is reassuring the content was seen as relevant by almost all involved in the programmes, including the pupils. However, it would seem that measures, such as enhanced initial communication, negotiation and then co-teaching can ameliorate concerns and misconceptions some staff can have about the nature and salience of the content.

■ Communication between the health board and schools

Communication when setting-up the programme

These collaborative programmes depend on effective communication. In general, communication seemed satisfactory but there seemed to be some room for improvement concerning informing and familiarising teachers about the aims and nature of each programme.

Collaboration between agencies is time consuming in planning preparation and teaching programmes and teachers, in particular, felt that time constraints meant they could not devote as much time to these aspects as they would like. The teachers and the health workers involved in each programme generally felt ideally that there could have been more communication between all involved in designing and delivering the program. These discussions could have been beneficial in clarifying the aims of the progress and approaches used. However, there had been an effort to gather views at the outset. Numerous meetings and negotiation between health workers and teachers had occurred in an attempt to devise a suitable course for the school. However, while the PSD teachers said that they saw various documents, materials and the broad headings of the syllabus, they felt that it was difficult to know the details of the content and teaching styles and what the overall aims of the programmes were. When asked whether they would like more discussion to be introduced at the setting up stage of such programmes, teachers felt that it would be difficult given the time constraints.

In the case of the sexual health programme, there had been some upheaval at the beginning of the programme with one of the health workers who had negotiated the programme with the school obtaining other employment. While this did not seem to affect the quality of the delivery of the programme, it did appear to lead to some misunderstanding about why the intended co-teaching model of delivery was not used.

Communication during the programme

Once the programmes were running, the teachers and health workers did have opportunities to meet and discuss their course. This included health workers being invited to PSD meetings. Meetings and informal discussion between the teachers and the health workers proved to be effective in allaying some of the

concerns teachers had about the content and the methods used in delivering it and also allowed the health workers and teachers to appreciate each others views, further reduce anxieties and promote trust.

Communication including negotiation plays a crucial role in tailoring the programme to the needs of the school and allowing any concerns staff might have to be addressed. While the time available to communicate during the setting up of programmes might be limited, spending time at this stage of the project can help reduce confusion and misunderstandings concerning the nature of the programme.

■ Assessing the needs of pupils

Reflecting the needs of pupils is one of the most important aspects of designing and delivering a health education programme. However, assessing the needs of particular pupils to inform the design of a programme is often constrained by resources and other practical factors. Usually, some assumptions have to be made about the pupils' needs when designing the course and any unforeseen needs met by the flexible nature of the health workers' delivery.

In both programmes there had been no systematic assessment of pupils' needs before the programme began because of the constraints of time and personnel. As a result the programme content was based on the separate assessments of (a) the Health Board's awareness of young peoples' needs arising from research and their previous programmes and (b) the PSD teachers' input about content based on what pupils had told them should be provided. In addition, the health workers on both programmes were very flexible in delivery of the content in responding appropriately to pupils questions. This enabled the content to be adaptive to the real concerns and needs of pupils.

It is vital that courses in sexual health and the use of potentially noxious substances should match the current need for information and guidance for each pupil. However, time and resources limit the extent to which programmes can be tailored to suit particular schools and their pupils, therefore the responsive nature of the teaching has to 'fill in' any gaps in the content. However, our findings suggest that any effort to find more time to build in some form of systematic assessment into the first session of a programme could assist health workers to prioritise topics in the programme content to suit the demand from pupils. Health workers would, therefore, be sensitised to the 'real' concerns of pupils and could gear the programme to these. Even with a more systematic needs assessment, there will probably always be a need for health workers to respond 'on-the-spot' to any questions which emerge as the programme progresses.

■ Staffing

The programmes we evaluated used and benefited from different styles of staffing. The modified drugs and alcohol programme differed from the school's own programme in that it used a co-teaching approach, with the health worker or local addiction project worker usually delivering the majority of the programme with the PSD teacher assisting, often with class management. The pupils who received the modified programme were more likely to say that they had learned more and found it an enjoyable and stimulating experience. For various reasons,

the sexual health programme used only health workers to deliver the content. Pupils had stressed that this is how they wanted to be taught and was one important reason for abandoning the intention to use co-teaching. For reasons of potential embarrassment, confidentiality and fear of disclosure, the pupils both before and after their programme felt that health workers were the most suitable people to teach them about sexual health. A fear of being judged by teachers was yet another reason for pupils wanting health worker only delivery. Not only was this model of teaching appreciated by pupils it also appeared to be effective in inculcating knowledge and initial decision-making skills. While a co-teaching model was appreciated for the drug and alcohol programme, it appears that the increased sensitivity of sexual health meant pupils on that programme felt that any teacher presence was unacceptable.

Most of the teachers we spoke to wanted health workers to deliver most if not all of the programmes although they realised that this would be costly and were, therefore, willing to train to deliver aspects of programmes they felt comfortable with. Teachers saw health workers as having the necessary expert knowledge and therefore credibility to deliver this type of health education. Teachers like their pupils were also worried about personal disclosure and potential loss of credibility in the eyes of pupils and parents. In addition to a fear that teaching on such programmes could conflict with their perceived professional role, one teacher on the drug education programme felt that the programme content and ethos conflicted with their personal views on the subject. While only one teacher on both programmes felt this way, this does raise questions about selecting staff to co-teach or solely teach programmes which can involve moral or ethical issues. Such concerns of teaching staff and others involved in delivering sexual health and drugs education programmes could well inhibit the formulation and implementation of effective programmes for pupils. The findings of other research such as Thomson and Scott (1992) draw similar conclusions.

> The overall impression gained from the survey suggests that the anxieties of those significant adults involved in the provision of sex education is overriding responses to the needs of the young people receiving the education.

The demand from pupils and many teachers for co-teaching and health worker-only teaching on such programmes can create a number of dilemmas for those who design, fund and implement the programmes. Firstly, given the limited numbers of health workers, how can health worker intensive programmes be implemented on a large scale. Teacher involvement of varying levels, could reduce the overall reliance on health workers. On the other hand, if programmes which use substantial health worker input are demonstrably more successful than teacher-only programmes (as our research implies) then it will be a better investment of time and money to pursue this model of teaching. The long-term effectiveness of programmes will have to be taken into account when assessing the costs of staffing programmes.

Whatever the best model of delivery, whether it is primarily health worker delivered or is a mix of co-teaching and health worker-only delivery, the findings of this report suggest that successful health programmes will depend on efficient and willing collaboration between health boards, education departments (including schools) and government. These parties will also have to demonstrate their willingness with material investments to resource appropriate programmes.

The training needs of teachers

For both sexual health and drug and alcohol programmes teachers perceived a need for more training to improve their subject knowledge as well as how to discuss sensitive topics. But perhaps the PSD teachers already possess the most important skill, that of teaching pupils about decision-making skills and assertiveness. PSD programmes place an emphasis on assisting pupils to make informed decisions about other aspects of their lives. As one health worker pointed out, teaching decision-making skills is at the heart of health education. This teaching strength could be built upon using training provided by health board staff to address those aspects of health education programmes teachers feel less able to deliver.

Programme content, teaching and length

Content of the course

The actual style adopted by health workers involved covering the syllabus or course outline but also responding to pupils' questions, questions which could fall outwith the formal syllabus headings. It is possible that, while health workers' flexible and responsive style is the most appropriate to meet an often extremely diverse range of pupil needs, it could create dilemmas for those who design and deliver sexual health and drug and alcohol education courses. For example, sexual health programmes may have to respond to the needs of younger pupils by discussing topics which are seen by some as appropriate only for older pupils.

A responsive approach, which our findings have found to be extremely valuable and effective for pupils, could be threatened by the current political climate. In England and Wales, the content of sexual health education has come under scrutiny from some politicians, with criticism being levelled at any discussion of issues seen as 'inappropriate' for younger pupils. Some ministers have gone so far as to suggest that teachers could be threatened with possible legal action if they gave advice on contraception to pupils under 16 years of age.

One could argue that such pressure will not only limit the ability of health education programmes to meet pupils needs but also deter teachers from becoming involved in teaching sexual health courses. Teachers are anxious enough about their ability to acquire the necessary subject knowledge and credibility to deliver courses themselves or even co-teach. The possibility of facing legal action if they discuss certain issues, which pupils might well raise because they have a genuine need, could severely limit teacher involvement in sexual health education. It is also possible that health workers could face similar pressures to those of teachers if ministerial pronouncements become hard policy. In short, effective sexual health education in schools could be severely hampered if the area becomes the focus of a political and media 'moral panic'.

Teaching methods

Classes were usually divided into two groups of approximately 15 pupils in each with the sexual health programme using single sex groups with a health worker of the same sex delivering the content. If pupils had questions which they were too embarrassed to raise in front of the group they could talk to the health worker after the class or, additionally, in the case of the sexual health programme, write them down and put them in a box and the questions would be answered at the next session.

Apart from a flexible syllabus and responsive teaching styles, the actual teaching methods used on the health education courses were quite varied: the health worker talking to the group; discussion; use of flip-charts; worksheets/ self-completion materials; reading materials; videos (drug and alcohol programme only); role-play; quizzes and in the case of the sexual health programme models (for example, using fruit to represent body parts), and for S3, planned opportunities to examine and discuss contraceptives.

Pupils were generally very satisfied with the diverse and entertaining methods which, they claimed, helped maintain their interest and encouraged them to learn more. Discussions were the most appreciated teaching method across the programmes because they allowed pupils to learn about others' views and also to get their questions answered by the health worker. Documentary or soap opera style videos were particularly appreciated, but pupils were critical of videos when the content was ambiguous, looked dated and was not relevant to their lifestyle. Across the two programmes, pupils were extremely eager for 'hard facts' which were presented in an explicit fashion. If pupils felt they were being denied information or punches were being pulled, the method and associated message would lose credibility.

Of particular significance was the fact that role-play appeared to help develop decision-making and assertiveness skills in pupils. Pupils said that role-play helped them think through possible scenarios and what others could think about certain decisions.

As the PSD teachers had limited or no participation in the actual teaching of the programmes they depended on feedback from pupils, and informal discussion with the health workers to inform them about the methods used. Some of the teachers felt that the methods were similar to those used in PSD work but it is likely that they would need support to develop role play as a more frequent method than they are accustomed to use.

One problem course designers face is that if certain methods are used for particular groups and not others there could be some dissatisfaction from 'excluded' groups. For example, on the sexual health programme S1 pupils were not given the same planned opportunity to examine contraceptives as S3. S1 felt they could have benefited from a similar exercise mostly because the information would be useful in the future but some also said they needed this information now. This relates to the issue of assessing pupils' needs but political pressures could well impinge on the decision to cover this matter with younger pupils.

The message about methods is clear. Pupils appreciate accurate information presented in a diverse and stimulating fashion with the opportunity to discuss at length the issues the information raises.

Length of programmes

Both programmes lasted approximately 10 weeks. This proved satisfactory for all concerned on the drug and alcohol programme but not for those involved with the sexual health programme. The pupils wanted more time, not because of faults in the programme but rather to cover issues generated by the content. The health workers felt that a more effective course length would actually be shorter (about five weeks long) but focused on fewer topics which could be covered in more

detail and allow more time to answer pupils' questions. The content of the more focused programme would be identified by the school to reflect pupils' needs and the methods of delivery could be negotiated between the school and Health Board. Such programmes could draw on packs and 'customise' them to suit the school's needs.

The benefits of this approach seem clear, but care needs to be taken in selecting the topic(s) to form the basis of the programme. How would pupils' needs be assessed and taken account of in the content of the programme? If only one topic was covered per programme (say HIV/AIDS) would other pressing needs (such as information on contraception and resisting peer pressure) wait for a subsequent programme? Our findings suggest that most pupils want information and advice on two or three equally important sexual health topics at the same time with other subsidiary topics covered as appropriate. Could a programme based on only one topic satisfy pupils' often extensive requirements for sexual health information?

A series of such programmes might be needed to address the range of needs pupils have. Would this be as resource intensive as the longer, more varied programme we evaluated? One answer might be shorter programmes aimed to cover two or three main 'key' topics and issues in depth while providing 'first-aid' basics about other aspects of sexual health on informative and accessible poster/leaflets? However, such methods might discriminate against those pupils who have literacy difficulties and should not be a replacement for discussion with pupils. Alternatively, pupils could be notified about sources of information and advice which they could drawn on if they had questions about topics other than those covered in the focused programme. Whatever the solution, the issue remains how do programmes meet a wide range of pupils needs in a practical, effective and resource friendly way?

■ Improving pupils' decision-making

The impact of the programmes

Most pupils thought their programme had sensitised them to decision-making options and had begun to help them develop relevant skills. While pupils felt their programmes had helped them in relation to decision-making including resisting peer pressure, pupils were still aware that this type of pressure was an ever present factor.

In the case of the sexual health programme, pupils felt better able to make 'safer sex' decisions than they had been before the programme started. In particular, some girls felt better able to resist peer pressure particularly from boys. However, pupils were still realistic about factors which could still affect their decision-making capabilities. These included being drunk or overly excited when the opportunity for sex occurred and the desire for sex could then override practising safer sex.

The modified drug and alcohol health education programme had increased pupils' knowledge and awareness of drug and alcohol related issues and promoted, in the view of the pupils, their decision-making concerning these areas. However, pupils already seemed relatively well informed about tobacco smoking and did not feel the programme had added greatly to what they already knew.

Staff on both programmes were cautiously optimistic about the impact of the

programmes on pupils' decision-making abilities. It was thought that real developments in this area were long-term goals which would only be met if the message of the programmes were reinforced by subsequent programmes throughout the pupils' school life.

The importance of peers

All pupils gained much of their knowledge from their peers. What is less certain is the extent of misinformation they also obtained. Pupils want to appear knowledgeable to their peers and at the same time to seek information from them. What their friends thought and said about them was extremely important in shaping what pupils thought and did. They experienced pressure to go out with someone or experiment and to conform with what seemed to be the peer norm .

An important finding was the pupils' suggestion that educating classes simultaneously across whole year groups within the school weakened negative peer pressure and encouraged 'peer support'. Are these better informed pupils seeing sexual and drug related issues more in perspective? Their individual decision-making abilities may well be increased by the programme but another effect, a cumulative effect of the change at individual level, could be a positive shift in the whole pupil culture concerning health issues.

The importance of peers and socialisation processes in relation to patterns of health behaviour has been demonstrated by other research. For example, Curry, Todd and Wijckmans (1993a) found that

> Many of the behaviours that are considered potentially health compromising are in fact used by young people to aid socialisation. Indeed they form a crucial part of the socialisation process.

Therefore, peer relationships and the socialisation processes involved are not only important in the transmission of ideas and information but also in reinforcing certain behaviours which can be health compromising. The pressure to conform in order to be accepted by one's peers and to feel valued by the group can have implications for health behaviour. Programmes which aim at improving the awareness of pupils concerning their health and their related decision-making will have to take into account peer relationships and socialisation processes.

We do not know how permanent such a shift in attitudes and pupil culture will be without reinforcement from subsequent programmes. Nevertheless, it would seem that the implementation of programmes which aim at improving knowledge and decision-making concerning health should be school-wide exercises. This will have more of an impact on the overall school culture. Following a programme, peer discussion of sexual health will be informed by a 'boost' of accurate information. If the programme is delivered to all year groups at once, the chances of the facts being distorted as they pass from pupil to pupil will hopefully be reduced.

The long term effects of a one off programme are uncertain. It is likely that in the sensitive areas covered by both these programmes, a spiral curriculum is essential: pupils from S1 and S2 need to revisit the topic of sexual health as their own development progresses and as they meet new challenges in making decisions.

3 EVALUATION FINDINGS

Here we present detailed summaries of the findings from the evaluation of the two health education programmes. The format of the following summaries of the main findings arise from each evaluation and their particular issues differ reflecting the differing structure of the individual project reports from which they were taken.

■ Drugs and alcohol: the findings

Our evaluation can report that the subject area covered by the modified programme, especially drug-related issues, was seen as very relevant by all of the pupils we spoke to. The most important general points are:

- there was a clear need for the modified Drug and Alcohol Health Education programme which was seen by the S2 pupils as very relevant.
- the modified Drug and Alcohol Health Education programme has increased pupils' knowledge and awareness of drug and alcohol related issues and promoted, in the view of those pupils, their decision making concerning these areas. Pupils already seemed relatively well informed about tobacco smoking and the programme did not greatly add to their knowledge on this topic. However the nature of the modified programme allowed pupils to a large extent to direct the agenda. This reflected their main concerns and needs which were related to drugs and related issues. The pupils on the standard course also shared this topic as their main concern but their course was more structured and so entailed more attention to alcohol and smoking. The predominance of interest about drugs and related health issues among pupils is, therefore, reflected in the content of this report.
- maintaining or increasing resources for such programmes would be justifiable but are not necessarily large and some improvements do not need a substantial outlay, for example, better information sheets and use of role-play.
- the importance of external workers. The presence of external project workers (including health board and local addiction project personnel) on the modified programme was valued by teachers and pupils because of their increased subject knowledge and related credibility and also because they were more able than teachers to be, or be perceived as being, non-judgmental.

In addition to these four main points the main themes to emerge from the evaluation findings were:

Communication between project workers and teachers

- teachers and project workers perceived the need for greater communication between themselves to clarify the aims of the project and how best to prepare and organise class work.

Meeting the needs of pupils

- pupils' needs were addressed progressively with the project workers responding to issues raised by pupils as the course developed. However, teachers and project workers felt that more thought could be given to assessing pupils' needs prior to the course.

Satisfaction of pupils with their programme

- in comparison with standard course pupils, those pupils who had done the modified course appeared more satisfied with content, delivery and the ability of the course to inform their decision-making skills, particularly in relation to drug related issues. It seems that a combination of inter-connected dimensions – the content, methods of delivery and the people who deliver the course – was responsible for the relative success of the modified course.

Delivery methods

- pupils appreciated relevant content delivered through varied and stimulating teaching methods and materials. Discussion groups and role-play were particularly valued. Such diversity was more likely to be found on the modified courses. Videos which lacked detailed information and/or were outdated in appearance were heavily criticised. The project workers, and to a lesser extent the teachers, shared these views.

Staffing and resources

- teachers initially lacked confidence in terms of dealing with aspects of the course content, particularly that on drugs. This diminished as the course progressed and was most noticeable on the modified course where they benefited from co-teaching with the project workers.

- the issue of time emerged strongly. The two previous points - assessment of pupil needs and building in communication between teachers and project workers - required more time than was available. More time was also seen as necessary to increase the efficiency of the teaching methods, for example, to provide double period classes to allow discussion of issues raised by videos.

Collaborative teaching

- despite gaining confidence with the subject matter, teachers who had experienced co-teaching on the modified programme felt that this format should be used in the future rather than a teacher only experience. The main reason for this was that project workers were perceived by teachers

and pupils as having more experience of working in this area and possessing specialist knowledge. The teachers were also aware of their limited credibility in the eyes of pupils because they were not seen as the 'experts' on the subject;

- teachers were concerned that they were in an awkward position because the role of teacher could constrain them in the areas of:

(a) confidentiality (eg some felt that if they were told of a pupil's drug use they might have to refer the matter regardless of the pupil's wishes).

(b) self-disclosure (eg in assisting rapport with pupils by describing their own views and experiences).

In addition teachers were aware that pupils saw them as having a disciplinary role which, again, could limit their rapport with the pupils on sensitive issues.

Issues for consideration

Rather than raise recommendations on the basis of our findings, we feel it is more appropriate to suggest some question areas for consideration. These include collaborative and practical issues and moral/ethical dilemmas.

Resourcing an effective course

1. How can the desired increase in time be found to facilitate:
   - improved communication between project workers and teachers,
   - better preparation
   - extending the length of class sessions to promote more effective group discussion?
2. If pupils and their teachers see the way forward in health education in their school involving external project workers, and our findings appear to verify this enthusiasm, how will such programmes be financed and run? Practical considerations such as the availability of project workers and the funding for their work in schools as well as the need to promote and integrate the role of the teachers on the programme may well place a limit on the wider use of external workers over time and across many schools simultaneously.

Staffing issues

3. Could more efficient use be made of suitably experienced and qualified staff present in the school but who are not currently involved with the programme?
4. Only one teacher involved with the programme expressed some serious reservations about the ethos of the programme and the content. However, should more guidance and advice be available to staff to help address any:

   (a) personal dilemmas that could arise from a conflict of personal views with the programme goals and message?

   (b) conflict of professional roles?

Consolidating programme effects on pupils' knowledge and decision making and monitoring the long-term effectiveness of such programmes

5. The teachers and particularly the project workers stressed that the goals of the programme would only be fully realised over a long period of time. Will future programmes follow on from initial programmes. Should such programmes be developed for younger pupils with 'follow-up' courses being provided throughout school life? If so, how will the effectiveness of such programmes be monitored over time?

■ Sexual health: the findings

Staff hopes and fears for the programme

Staff were enthusiastic about the aims of the programme. They hoped it would provide pupils with information and advice to increase their knowledge of sexual health, provide information about areas particularly relevant to the concerns of certain age groups (eg, puberty and pregnancy) and to demystify sex and related issues. They were concerned initially about the content of the programme and its relevance to the differing needs of pupils. These anxieties were reduced as the classes progressed and positive feedback emerged from the pupils. While concerns about how health workers would cope with the more 'disruptive' or demanding pupils diminished during the course of the programme, there remained some role conflict for teachers in working with pupils in areas of sexual health education.

Suitability and relevance of content and language

The overall content of the programme negotiated between health workers and the school, covered four main areas: puberty; contraception; HIV/AIDS; and relationships but, through lack of time, there had been no systematic assessment of pupils' needs before the programme began.

All staff thought that the content proved relevant and responsive to pupils' needs but health workers thought that there was insufficient time to deal with some topics in more than a superficial way.

Teachers were concerned about some of the terminology used and some topics which might emerge in younger pupil groups. The health workers realised that pupils felt comfortable using their own terms and would therefore speak more openly. However, the health workers set their own ground rules on the use of popular language which included prohibiting the use of terms which had derogatory connotations or uses.

Staff views on the programme's effectiveness

The teachers were cautiously optimistic about the effects of the programme on pupils' levels of sexual health knowledge and were pleased to find that their pupils had enjoyed the programme and found it useful. Health workers felt it was clear that the pupils still had many questions and wanted more detailed information than the basic facts on the topics covered.

The teachers and health workers felt that the provision of information and facts about sexual health would facilitate the development of decision-making, empowerment and assertiveness skills in pupils. However, they considered the

ability of this and similar programmes to affect development of such skills in pupils had to be seen as a long-term goal.

Staffing the programme

The intention of such programmes is that teachers should be involved in co-teaching to promote a real sense of ownership of the course. However, this had not happened partly because of pupils' reticence on having teachers present during the classes. In addition, there appeared to be some confusion between those involved in setting up and delivering the course as well as the teachers themselves on what was the most desirable way of teaching the course.

The PSD teachers, none of whom had previous experience of working with sexual health education at this level, all felt that bringing in health workers was essential in delivering the programme. The health workers were seen as having the necessary subject knowledge and expertise in teaching sexual health that the teachers lacked and, therefore, more credibility than the teachers in talking about these subjects. However, there was also demand for training and experience of co-teaching to enable them to take more of a role in future programmes.

One effect of there being no co-teaching on the programme was that PSD teachers had very little opportunity to pick up much of the subject knowledge and new delivery skills they felt they lacked. This appeared to affect the teachers' confidence when considering their role in any future programme.

Future sexual health programmes for the school

All of the teachers were willing (to varying degrees) if training was provided and back-up support was available, to play a greater role in delivering the courses. However, the teachers had some anxieties about their future participation in any sexual health programme. These anxieties were largely based on their belief that:

- they lacked the necessary subject knowledge, and therefore, credibility in the eyes of their pupils.
- pupils did not want teachers to deliver such courses because of reasons such as embarrassment and confidentiality.
- they might face dilemmas such as dealing with embarrassing issues, the possibility of self disclosure and the possibility of some parents complaining about teachers covering certain material and terms in the sexual health programme.

Health workers and teachers thought that any future programme should involve both parties not only because resource implications meant that a health worker intensive programme was impractical but also so that the teachers and pupils should have ownership of the programme.

The health workers suggested future programmes should consist of shorter courses, lasting five or six weeks, which were more focused on certain topics and would allow these areas to be covered in greater detail. The actual content of these shorter courses would be based on the school's needs and careful negotiation between health workers and schools would be essential to adapt basic materials and content to suit these needs.

The needs of pupils as defined by the pupils

There were some differences in pupils' needs according to their year group and sex and there were also similarities across the year groups for the same sex. All groups of pupils wanted more information about the other sex's development and 'how they worked' as well as HIV / AIDS, contraception, and sexual orientation. Boys wanted to know about sexual techniques and girls had more broad questions related to bodily developments (especially S1 pupils), the legalities of sex and how to deal with pressure from boys.

Many of the areas the male and female pupils wanted information on were characterised by their varying degrees of understanding of sexual health issues being compensated by some quite fanciful thoughts or myths. In some cases these misunderstandings could have had serious and dangerous implications. For example, there was confusion across year groups and between girls and boys about contraception, safer sex practices and the transmission of sexually transmitted diseases.

Pupils' concerns and worries about the programme before it started

The main worries pupils had about the programme before it actually started were the same across the year groups and very similar between sexes. They had two major concerns:

- a fear that what was discussed would not be kept confidential either because classmates and/or teachers might repeat what was said in the classes to others.
- a fear of being embarrassed when talking about sexual health, particularly if they were seen to lack knowledge of what was being discussed. Related to this was the fear of possible ridicule from classmates if they said something which was inaccurate.

Some pupils were anxious that their teachers would be involved in the delivery of the course and most girls were worried about any possibility that the boys would be in the same class during the sexual health programme.

Pupils' views on the content and delivery of the programme

Boys and girls across the three year groups were generally very satisfied with the content. While there were only small numbers who said things were missing or had not been addressed in enough detail, girls wanted more information and advice on: HIV / AIDS, sexual orientation, about the feelings and development of the opposite sex and pregnancy and abortion (mainly specified by S3 girls). Younger pupils wanted to know about masturbation and S1 and S2 (particularly boys) wanted demonstrations of contraceptives and their use. Only the S3 boys tended to say that there was too much repetition of points, particularly about HIV / AIDS.

Pupils were generally very satisfied with the teaching methods used, particularly because they were so diverse and entertaining which, they claimed, helped maintain their interest and so learn more. Discussion was the most appreciated teaching method because it allowed pupils to learn about others' views and also get their questions answered by the health worker. S1 would have liked more detailed discussed on contraception mostly because the information

would be useful in the future but some also said they needed this information now.

Effects of the programme on pupils' subject knowledge and decision making
There was consensus across the year groups and between boys and girls on their enjoyment of the course and this was primarily due to their satisfaction with the content in that it had covered most of what they had wanted to learn - HIV / AIDS and contraception being the most important. Peer pressure was perceived as crucial in affecting the acquisition of sexual health knowledge and in affecting decisions. Boys were concerned about whether or not to use condoms and assess the risks of HIV infection. Girls thought decisions about divulging information about their private lives and responding to pressure from boys to have sex would be important for them.

While most pupils said the programme had promoted their decision-making skills only S3 girls said that one of the most important things they learned from the course was assertiveness and decision-making skills. This could imply that other groups of pupils were less satisfied with the course in terms of helping them to resist peer pressure but possibly the issue was more salient to the S3 girls. Most pupils thought the programme had sensitised them to decision making options and had begun to facilitate the development of relevant skills. For example, they felt better able to make 'safer sex' decisions than they had been before the programme started. However, pupils were still realistic about factors which could still affect their decision making capabilities.

Girls in all year groups, but particularly S3, said that they were more confident of being able to say no if they felt they were being pressured by peers and boys and claimed that if, and when, they were likely to have sex they would be firm about safe sex and the use of condoms. First year girls felt that, because whole year groups were receiving the programme, peer pressure was becoming peer support based on new information and ideas they had discussed.

Pupils' views on who should teach the course
Pupils were adamant that teachers should not be present during classes, only some of the girls wanted their teacher present at the beginning until it was clear what was involved. The issues of confidentiality and trust, embarrassment and the possibility of being judged shaped pupils' reasoning for not wanting teachers present. Pupils did agree on the conditions necessary for a teacher to be involved in the delivery of the programme. These were that teachers could demonstrate they respected the pupils' views, accepted them for who they were and maintained the strictest confidentiality.

All of the pupils across the three year groups were extremely positive in their opinion of the health workers. The pupils' enjoyment of the course was primarily based on their satisfaction with the health workers who made good relationships with the pupils, were clear and unembarrassed about topics and allowed the pupils to speak freely.

Conclusion and emerging issues

Overall it was clear that the sexual health education programme delivered by health workers had been responsive to pupils' needs for accurate information provided in a supportive context. Pupils felt their knowledge and ability to make decisions in this area had been enhanced.

The topics covered in the syllabus could not be said to be only applicable to one age group. Pupils in the first year of secondary school requested information which was available normally for S3. This poses a curriculum dilemma in terms of whether or not it should be responsive to pupils' needs and wants whatever their age. The optimum length of a sexual health course is also debatable.

Although staff were interested in co-teaching the programme, this proved difficult because t chers were ambivalent about their roles and expertise in sexual health educ ion. Areas which could benefit from further exploration are:

- What are the most suitable staffing arrangements for sexual health programmes?
- To what extent can off-the-shelf teaching packages be used on programmes and how are pupils needs best assessed in a practical way?
- What are the processes involved in peer pressure and learning and the resulting influence on decision making? How does information, misinformation, pressure and support interplay within peer groups?

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Appendix 1: Research Methodology

Summary of samples and methods:

(a) Drugs and Alcohol Education programme;

(b) Sexual Health Programme.

(a) Drugs and Alcohol Education programme:

Teaching staff and project workers

In the evaluation of the drug and alcohol project we spoke to five teaching staff involved with the course, one addiction worker and three health workers. The views of teachers and project workers were obtained using semi-structured, in-depth group interviews. Occasionally, these sessions were allowed to develop into 'structured eavesdropping', where the group would discuss the question areas put to them by the researcher who would intervene only to ensure the discussion stayed on course or to introduce other relevant topics.

The question areas which were the basis for the drug and alcohol programme evaluation teaching staff and project worker interviews were derived from the main objectives set by the Health Board and focused on:

- hopes and fears for the programme;
- relevant previous experience of staff and workers which assisted the programme;
- communication and decision-making issues in setting up the programme;
- experiences in co-leading the programmes;
- recommendations for implementing future drugs programmes within the school.

Each session was tape-recorded and fully transcribed and returned to participants for comments on accuracy. From the transcripts summaries were produced. These summaries formed the basis for the analysis. Analytical categories were derived from the initial research questions set by the Health Board in their specification for this evaluation and subsequently elaborated in collaboration with the researchers (as set out above). Any additional categories and topics which emerged from the responses as the analysis continued were also used. Particular attention was shown to any 'themes' which commonly occurred in responses, such as praise, criticism and observations regarding certain aspects of the programmes.

Pupils

In the drug and alcohol evaluation we were comparing pupils' views from a modified programme (which had used project workers to co-deliver a revised content) with those of pupils who had received the standard programme (which had used teachers only and the basic modular drugs and alcohol package). We

selected four S2 'modified' classes (a total of 65 pupils) and four 'standard' classes (a total of 63 pupils). There were approximately equal numbers of male and female pupils in each of the classes we gathered information from.

The methods used to gather information from pupils were group interviews and self-completion sheets conducted during their one hour PSD (Personal and Social Development). Each class involved was divided into two random groups in separate rooms with a researcher leading each session. No other adult was present. The self-completion exercise was undertaken in the last 15 minutes of the session and enabled all pupils in the groups to provide their views in confidence. This helped safeguard against information only acceptable to the group consensus being collected. Also, it allowed information to be collected from less assertive pupils who might have been excluded from giving their views in the group discussion.

The question areas used in gathering information from pupils were:

- did the programme address their needs and cover the issues they saw as important?
- were the teaching methods and materials conductive to learning?
- was the use of outside tutors (project workers) seen to be effective?
- did the programme lead to an increased knowledge of the subject matter and relevant support services?
- did the programme increase pupils' decision making skills in relation to various drug-related and health-risk scenarios?

Respondent Group	Sample	Methods
Teachers and health workers	As set down in the bid document: 2 Health promoters 1 Addiction project worker 5 Teaching staff	Structured eavesdropping/group interviews involving health workers and teacher combinations
Pupils	All S2 4 classes who received standard programme = 63 pupils 4 classes who received modified programme = 65 pupils Approx. equal numbers of boys and girls in the classes	Group interviews/sessions using questions based on research objectives. Self completion folder with 4 sheets to gather their personal views of programme and levels of knowledge. Materials based on those used by the programme to reflect appropriate language and literacy skills.

(b) Sexual Health Programme:

Teaching staff and project workers

In the evaluation of the sexual health project we spoke to nine teaching staff involved with the course, three health workers, one of whom had been involved in the setting up of the programme but had obtained employment elsewhere before the programme started. The views of teachers and project workers were obtained using semi-structured, in-depth group interviews. Occasionally, these sessions were allowed to develop into 'structured eavesdropping', where the group would discuss the question areas put to them by the researcher who would intervene only to ensure the discussion stayed on course or to introduce other relevant topics.

The question areas were the same as for the evaluation of the drugs and alcohol programme. The procedures for collecting information were also the same.

Pupils

In the sexual health programme evaluation we wanted to relate the sexual health programme to pupils' needs and expectations. We therefore, gathered information from pupils by interviewing pupils before they received their sexual health programme (to asses their needs, hopes and fears) and after they had completed the programme (to assess how well they felt programme had meet their needs). We randomly selected three classes each from S1, S2 and S3 (this allowed us to gather information from a total of 186 pupils before the programme and 173 after).

Again the methods used for collecting information from pupils were the same as those used in the evaluation of the drugs and alcohol programme. However, the only difference was that each class involved was divided into in single sex groups (the same groups in which they were to receive the programme) in separate rooms with a researcher of the same sex as the group leading each session.

Respondent Group	Sample	Methods
Teachers and health workers	As set down in the bid document: 3 Health project workers 9 Teaching staff	Structured eavesdropping/group interviews involving Health workers and teacher combinations
Pupils	3 classes randomly selected from S1, S2 and S3 The classes were interviewed before and after their programme. See table below for totals and breakdown of pupils interviewed by their gender	Group interviews/sessions using questions based on research objectives. Single sex groups with interviewer of same sex. Self completion folder with 4 sheets to gather their personal views of programme and levels of knowledge.

YEAR	BOYS		GIRLS		ALL	
	Pre-prog	**Post prog**	**Pre-prog**	**Post prog**	**Pre-prog**	**Post prog**
S1	36	33	35	32	71	65
S2	23	27	37	34	61	58
S3	28	24	26	26	54	50
Total	87	84	98	92	186	173

Appendix 2: Content of Programmes

Content and Style of Health Education Programmes

Drug and alcohol programmes

- The 'standard' course -

  delivered by a PSD teacher using the *Drugwise too* modules[1] looking at drugs alcohol and smoking and based upon numerous worksheets many of which required self-completion. Teachers also deployed group discussion techniques as well as some videos;

- The 'modified' course -

  delivered mainly by a health project worker who had experience of drug and alcohol education with young people under the auspices of the Greater Glasgow Health Board. The PSD teacher worked in collaboration with a health project worker. The teaching methods were more varied than in the standard classes and included discussion groups, videos (the same as used on the standard course), role-play and the use of various texts including thematic information sheets which formed a poster when put together, and adaptation of the *Drugwise* module. The actual content was shaped by pupils and covered drugs alcohol and smoking but the emphasis was on drugs as a reflection of pupils' main concerns.

Sexual health programme

For each year the programme consisted of 10 sessions which were skills-based and adopted a participative approach. The sessions were delivered by health workers. In terms of structure, the modules were based on the well-established 'Skills for Adolescence' teaching package.

1st Year

Links in to Units 1 and 2 of Skills for Adolescence[2]

Subject headings:

- physical changes of puberty
- understanding how the body works
- feelings and relationships
- body image
- peer pressure

1 *Drugwise too* – is a modular educational package published by the Scottish Office and Strathclyde Region

2 *The Skills for Adolescence* modules are published by the Advisory Council on Alcohol and Drug Education (TACADE) a major charity which publishes support materials for teachers on all aspects of personal and social Education.

2nd Year

Links in to Units 3 and 4 of Skills for Adolescence.

Subject headings:

- puberty
- understanding how the body works
- feelings and relationships
- sexuality
- assertiveness
- body image

3rd Year

Links in to Units 5 and 6 of Skills for Adolescence.

- physical changes
- introduction to contraception
- sexually transmitted diseases
- basic health information – protecting your health
- self awareness and assertiveness
- decision-making and critical thinking
- peer pressure

Appendix 3: The Research Team

Research Team

Dr Janet Powney	Programme Manager
Kevin Lowden	Research Officer
Fiona Dick	Researcher
Joan Ballantine	Programme Secretary

Advisory Committee

Ian Young (Chair)	Health Education Board Scotland (HEBS)
Trevor Lakey	Greater Glasgow Health Board
Dr Carol Tannahill	Greater Glasgow Health Board
Dr Patrick West	Medical Sociology Unit (Glasgow University)

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